Acute Pancreatitis

Caused most commonly by **Gallstones** and **EtOH**, it presents with a **boring epigastric pain radiating to the back**, typically after a heavy meal or EtOH, that's **relieved** by **leaning forward**. Diagnosis is made by Amylase or **Lipase** being elevated (Lipase is the best as Amylase is also elevated in gallbladder disease and emesis). Treat it by giving the bowel rest, fluids, and analgesia (**IVF** + **NPO** + **Morphine**). This on its own is a medical condition and doesn't require further diagnostics or interventions. Complications and sequella, however, are a surgical topic. If the diagnosis is certain AND the enzymes are negative, get a CT. CT scan is NOT indicated for pancreatitis in order to make the diagnosis nor on the first day. The CT scan CAN be used to make the diagnosis of complications, but it should be reserved until after the complications are seen. The **BUN** is the single most useful prognostic lab test for Pancreatitis.

Necrotizing Pancreatitis

If an acute pancreatitis with a **poor Ranson's criteria** or it **needs pressors** it's safe to assume it's something more deadly than just pancreatitis. At this point, the "danger danger" signs should be going off (↓ **$PO_2$**, ↑ **$PCO_2$**, ↓ **pH**, ↑ **WBC**) and the patient needs an **ICU** and monitoring with **CT Scans -** as often as every day. Give **Meropenem** if and only if there's an **FNA-proven infection**. Surgery can be done later, a **necrosectomy** after the fluid collection has solidified.

Pancreatic Abscess

There are two ways one can get to abscess. The first is that necrotizing pancreatitis who is ill and stays ill. This is why **serial CT scans** become part of the treatment. But for the person with typical pancreatitis, an abscess will show on day 5(ish) with **persistent fever and leukocytosis.** This is the point where a **CT scan** should be ordered in a previously uncomplicated acute pancreatitis managed medically. When found, they need to be **drained**. The best is **percutaneous**; if severe, drain them **surgically**.

Pancreatic Pseudocyst

An abscess is an early sequelae of pancreatitis. A late sequelae is a **pseudocyst -** so named because it does not have an endothelial lining. In someone with mass symptoms (**dyspnea**, **ascites**, **and early satiety**), after acute pancreatitis suspect a pseudocyst. Get a **CT scan**. If **< 6 cm AND < 6 weeks** old, just watch and wait. If **> 6 cm OR > 6 weeks**, the risk of hemorrhage or infection is too great. They need to be **drained**: to the skin (**percutaneous**), the GI tract (**cystogastrostomy**), or surgically (**open**).

Chronic Pancreatitis

Patients present with **chronic pain** that mimics acute pancreatitis. Remember a few things about them: 1) it **can't be fixed** and surgery is contraindicated, 2) **treat the pain** - this hurts a lot, 3) they need to have their **DM**, **steatorrhea**, and **malabsorption** managed closely and medically.

*CT scan only if diagnosis positive and Enzymes negative*
*Right Upper Quadrant U/S for ETIOLOGY not diagnosis*
*Triglycerides for ETIOLOGY not diagnosis*